Division of Health Service Regulation

P.002/006

PRINTED: 08/11/2015 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
HAL092144		8, WING		05/13/2015		
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY,	STATE, ZIP CODE		
WAKE A	SSISTED LIVING	2800 KIDE	ROAD NC 27610	1		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PRIEFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
C 000	Initial Comments		C 000			
	This is a Report of a Blennial Construction Survey by Greg Cates and Billy Bryant on May 13, 2015.					
	Facility was first lice licensure on or abou	in gathered from our files, the insed or submitted for ut February 26, 1986 with		CONSTRUCTION	V SECTION	
	Sixty (60) resident b information, we are			#UN 23	2015	
Information, we are requiring the facility to meet the 1984 Homes for the Aged and Infirm Minimum Desired Standards, applicable portions of the 2005 Regulations for Adult Care Homes, and the 1978 Edition of the North Carolina State Building Code-Section 409.1; Institutional-Unrestrained.			RECE	VED		
C 133	Bathrooms-Hand Gr	ips	C 133	Completed 6/17/15		
	SECTION .0300 - PI 10A NCAC 13F .030 ENVIRONMENT (e) The requirement rooms are:					
	(6) Hand grips shall	i showers used by or				
	This Rule is not met 1- Based on observe provided grab bars in	tions, the facility has not				
	the commode and th	room, there is no grab bar at ere was not a procedure e bathroom inaccessible to		Grab bar installed 6/11 Procedure making public bathroom inaccessible resident use is that on staff have Kays for ac	to lay	
	Housekeeping-Maint SECTION .0300 - Ph	ained Free of Hazards	C 166	otherwise, the doors ver locked at all times.		
	alth Service Regulation	BASLIPPI IED GEPRESENTATIVE'S SIGNA	2	Administrator	(XII) DATE	

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_	Division of Health Service Regulation						
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
١	AND PLAI	PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	9: 01	COMPLETED	
L			HAL092144	B. WING		05/	13/2015
	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	STATE, ZIP CODE		
			2800 KID				
	WAKE A	8818TED LIVING		, NC 27610	•		
T	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(200)
	PREFIX		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE
	TAG	ACOUNT ON CO	ou lock in this he on marion	TAG	DEFICIENCY)	FMAIL	
	C 100	Cartinual Fara	4	6.400			
	C 166	Continued From page	ge 1	C 188			
			06 HOUSEKEEPING AND				1
		FURNISHINGS					
		(a) Adult care home	s shall: n an uncluttered, clean and				! !
			of all obstructions and	1			
		hazards;	or an exported to and		1		
			apply to new and existing				1
		facilities.			1		
		While Dute to con-					1
		This Rule is not me	t as evidenced by: ation, the facility has failed to				
			d environment clean and		1) [
	-	maintained.	d common didan and				1
							
		Findinge include:			ĺ		
		a. The exhaust for y	ents in most locations		Completed (40 AF and	. 31	!
			ing have a coating of dust		be maintained going	וויש	ا ا
		and lint.	ing riate a sociality of cast.		be maintained going.	torwa.	a.
	l		d doors have not been				
			coat to preserve the				
			ty of the door. Doors to				
		Include but not limite	sident Room 127)		completed 6/22/15		i 1
		- 1	to Resident Room 107		completed 6/22/15		
			to Resident Room 116 (also		completed 6/23/15		! !
	- (some delaminati					
			114, the chair rail above the		completed 6/25/15		
			eaving the exposed edge of				
		the plywood.	J				
		2- Based on observa	tions, the facility has failed to				
		maintain the building					- 1
			Ī	1			
		Findings include:					
		a. in Room 127 the	door on an overhead cabinet		completed 6/8/15		
		a-in Room 127, the d is falling off the hinge			45100-100 010113	1	- 1
			, the grab bar beside the		completed 6/8/15		1
		commode is loose at					

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Pergy & Dive Administrator

Division of Health Service Regulation

P.004/006

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
HALO		HAL092144	B. WING		05/13/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADD				STATE, ZIP CODE	•	
WAKE A	SSISTED LIVING	2800 KID RALEIGH	D ROAD I, NC 27810			
(X4) ID PREFIX YAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	COMPLETE DATE
C 168	c- The exterior light 116 is not working. d- In the Oxygen Sto oxygen bottles that a unapproved contain e- In the Resident C there is an electrical equipped with overlo	at the EXIT door near Room orage Room, there are are being stored in an er. are Coordinator's office, extension device that is not	C 168	completed 6/8/15 completed 5/18/15 completed 6/18/15	•	
	SECTION .0300 - PI 10A NCAC 13F .030 FURNISHINGS (b) Each bedroom al furnishings in good r resident: (7) Individual clean to bar in the bedroom of (e) This Rule shalf a facilities.	HYSICAL PLANT 6 HOUSEKEEPING AND hall have the following epair and clean for each lowel, wash cloth and towel or an adjoining bathroom; and pply to new and existing		as of 6/18/15, individual clean towels and was clothes will be main in resident bathrooms	ed ih tained	
		as evidenced by: tions, the facility has falled to uate number of towel racks		Completed 6/8/15		
		ident rooms, only two towel the shared bathroom for by rooms.				
C 189	Building Equipment N	Maintained Safe, Operating	C 189			
	mechanical, and plun					

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UTL821

Pages A. Smith Administrator

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Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING; 01		COMPLETED		
					l		
		HAL092144	B. WING		05/1	3/2015	
NAME OF	DOMOCO OD SUBBUIED	OVERT AD	DDESC COV	STAYE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIER			SIAIE, ZIF CODE			
WAKE A	SSISTED LIVING	2800 KIDI					
			NC 27610				
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	D BE COMPLETE		
TAG	MEGULATORY OR L	C IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	MAIL	WHILE	
C 189	Continued From page	ge 3	C 189				
	operating condition.						
		apply to new and existing					
		ception of Paragraph (e)		1			
	which shall not apply	y to existing facilities.					
	This Duty to put you	4 d d bor					
	This Rule is not me	t as evidenced by: atlons, the facility failed to					
	ensure that the fire				1		
		operating. The would afect			- 1		
		building if visibility in the			ı	- 1	
	corridor were limted						
	obijioo iio o mitoa	in an onio goney.					
	Findings Include:						
	a. The following em-	ergency lights do not		All completed on 6/8/	15		
		power, to include but not		All completed on 6/8/ and will be maintained	.	- 1	
ĺ	limited to:	portar, to monado por mor		The state of the s	.		
	1- EL #7				ĺ	- 1	
	2- EL #22					- 1	
-	3- EL#18	1		10 1 min to 1	-	- 1	
		T signs do not illuminate on		All completed on 6/8/1 and will be maintained	י ל	- 1	
		lude but not limited to:		and will be maintained	•	- 1	
	1- Kitchen				ĺ		
	2- At the West c	omdor EXIT				- 1	
	2. Based on observe	tions, the facility has failed to					
	maintain the fire ratir					·	
	mantani dio ino ran	y or the bearing.				.	
	Findings Include:						
- 1	o. Throughout the fe	sifty the college are starting		This mentack will be about	الما	1	
		cility, the cellings are starting		MIL DE SLEET	li Se	- 1	
		oints and other locations he one-hour rating of the		This project will be star 6/27/15. We will complet this project within 30 do We will provide before a	e-		
	,	ot containing fire or smoke		this project within 30 do	45.		
	from one smoke com		- 1	We will provide before a	ind		
		clude but are not limited to:	ļ	after pictures.		- 1	
	1- Resident Roor			(- 1	
	2- Shower Room					- 1	
		Room (Opposite Room 104)		_		- 1	
				A			

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Peggyd. Dmith Administrator

P.006/006

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Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED			
HAL092144		B. WING		05/13/2016			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY;	STATE, ZIP CODE			
WAKE A	BBISTED LIVING	2800 KIDE RALEIGH,	ROAD NC 27610				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(XB) COMPLETE DATE	
C 189	4- Resident Roc 5- Corridor outs 3- Based on observensure that the door the passage of fire occupants of the burpassage of smoke fanother. Findings include: a- The fire doors loc	-	C 189	Completed 6/8/15			

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Pagney & Duith Administrator